

NEW PATIENT APPLICATION

**Welcome to our Practice! Please thoroughly complete all questions.
Thank you.**

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Home _____ Work: _____

Cell #: _____ Marital status: M/W/D/S

Birthdate: ___/___/___ Age: ___ Social Security #: _____

Occupation: _____

Employer name: _____ Phone: _____

Employer's address: _____

Spouse's name: _____

Spouse's employer: _____

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic: _____

City, State: _____

Chiropractic adjusting techniques you've had success with: _____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner name: _____ Phone: _____

City, State: _____

Please rate on a scale of 1 (poor) to 10 (excellent) the quality of
healthcare you feel you receive from your GP: _____

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Children's names & ages: _____

Favorite hobbies or interests: _____

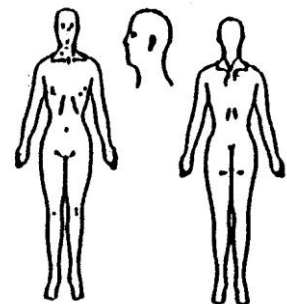
**Mark area(s) of
Health Concerns**

Health reasons for consulting our office:

1. _____ 2. _____

3. _____ 4. _____

Have you had same or similar problem(s) before? ___ Yes



How long?: _____

Please explain:

Father/Mother/Brother/Sister/Children, with similar problems?

Is this the result of an auto or work injury?_____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

Other doctors who have treated this problem:_____

Surgery you have had (ALL):_____

Medication(s) you currently take:_____

Is there any chance you are pregnant? Yes_____ No_____

What do you understand chiropractic care to be?

Do you know what a subluxation is? Yes or No If yes, please describe:

What daily rituals for spinal health do you presently practice?

Have you ever been diagnosed with cancer?___ If so, what type?

Do you have health (crisis care) insurance?_____ Name of company:_____

Name of Policy Holder _____ Relationship (self,spouse,parent) _____

Insured DOB _____ Insured SS# _____

Method of payment for first visit:

____Cash ____Check ____MAC ____Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____ Date:___/___/___

Authorization of release:

We at McCormick Chiropractic firmly believe that open communication between all of your Doctors is vital to optimal care being rendered. Therefore, we respectfully request your permission to forward relevant

information to the above stated Doctors.

*Permission to forward relevant information regarding my care to the above
stated doctors:*

Patient's Signature: _____